SUNWISE
Family Dermatology & Surgery

Jennifer LaRusso, DO, FACMS, FAOCD, FAAD
Gerard Stroup, PA-C

New Patient Registration

________________________ ____
(Today's Date) **(Email)**

Section 1 - Patient Information

____ _______/_______/__________
(Patient Name) **(Date of Birth)**

____
(Street Address, City, State, Zip)

___________________________ ___________________________ ___________________________
(Home Phone #) **(Work Phone #)** **(Cell Phone #)**

____
(Employer)

____
(Occupation)

Section 2 - Demographics

Language	☐ English	☐ Spanish	☐ Other		
Marital Status	☐ Single	☐ Married	☐ Widowed	☐ Divorced	☐ Other
Ethnicity	☐ Hispanic or Latino	☐ Not of Hispanic or Latino	☐ Unknown		
Race	☐ American Indian Or Alaska Native	☐ Asian	☐ Black Or African American	☐ Native	☐ Hawaiian
	☐ White	☐ Other			

Section 3 - Medical Care

________________________ (Primary Care Dr.)

________________________ (Primary Care Phone #)

________________________ (Pharmacy Name)

________________________ (Pharmacy Phone #)

Insurance Information

____
(Primary Insurance)

____
(ID #)

____
(Group #)

____
(Policyholder Name)

Is a Referral Required?

NO YES

_______/_______/___________
(Date of Birth)

____
(Secondary Insurance)

____
(ID #)

____
(Group #)

____
(Policyholder Name)

Is a Referral Required?

NO YES

_______/_______/___________
(Date of Birth)

Guarantor Information

(Required only if patient is a minor)

____
(Name)

_________/_________/__________
(Date of Birth)

____
(SSN)

________________________ (Home Phone #)

________________________ (Work Phone #)

________________________ (Cell Phone #)

____
(Employer)

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Section 4 - Patient Consent for Treatment

I consent to be treated by **Dr. Jennifer LaRusso DO** & **other healthcare practitioners** providing service at **SunWise Dermatology & Surgery**. I understand that I am responsible for and any all charges (or amounts based on payment arrangements agreed to by them) that are included during my treatment and not paid or otherwise satisfied by my insurance benefits or other third party benefits. Where Medicare benefits are applicable;

(a) I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct.

(b) I assign and request payment of authorized Medicare benefits to SUNWISE DERMATOLOGY & SURGERY, LLC.

(c) I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits of related services.

(d) I consent to the use and disclosure of my health information for treatment, payment & healthcare operations purposes as described in SunWise Dermatology & Surgery Notice of Privacy Practices.

____ ____________________

(Signature) **(Date)**

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Patient Intake Form

____ (Patient Name)

________/________ (Height / Weight)

Section 1 - Medical History

(Please check any box that applies to you)

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizure
- ☐ Stroke
- ☐ NONE
- ☐ Other ______________________

____
____
____

Past Surgical History

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast:Lumpectomy (Right, Left, Both)
- ☐ Breast:Mastectomy (Right, Left, Both)
- ☐ Colon (Colectomy) Colon Cancer Resection
- ☐ Colon (Colectomy) Diverticulitis
- ☐ Colon: Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Both)
- ☐ Joint Replacement: Knee (Right, Left, Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy) Endometriosis
- ☐ Ovaries (Oophorectomy) Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Prostate: Prostate Biopsy
- ☐ Prostate: Prostate Cancer
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Squamous Cell Carcinoma
  Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Testicles (Orchiectomy)
- ☐ Uterus: Fibroids
- ☐ Uterus: Uterine Cancer
- ☐ Uterus: Cervical Cancer
- ☐ NONE
- ☐ Other ______________________

____
____
____
____

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Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Carcinoma
- ☐ Blistering sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itching Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other ___________________

1. Do you wear sunscreen? Yes No
   a. If **Yes**, what SPF? _________

2. Do you tan in a tanning salon? Yes No

3. Is there a family history of Melanoma? Yes No
   a. If **YES** please circle: Basal Cell Squamous Cell Not Sure
   Please list relationship ____

Section 2 - Alerts

- ☐ HIV Positive
- ☐ Latex Allergy
- ☐ Pregnant or planning a pregnancy
- ☐ Breastfeeding
- ☐ Become faint or dizzy /with surgical procedures
- ☐ Blood Thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ History of MRSA
- ☐ Allergic to sulfa drugs or creams
- ☐ Allergies to adhesives
- ☐ Allergy to topical antibiotics
- ☐ Rapid heartbeat with Epinephrine
- ☐ Allergy to Lidocaine
- ☐ Yeast infections with antibiotics
- ☐ GI upset with antibiotics
- ☐ Active / History of Hepatitis
- ☐ West Africa: Travel or contact
- ☐ NONE

Medications - (List all current medications)

____

____

____

____

Allergies - (List all allergies and reactions if known)

____

____

____

____

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Smoking Status

- ☐ Daily Smoker
- ☐ Someday Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Unknown

____
Start Smoking (year)

____
Quit Smoking (year)

Alcohol Intake

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status

- ☐ Daytime
- ☐ Nighttime

Exercise Frequency

- ☐ Unspecified
- ☐ Several times daily
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other

Caffeine Use

- ☐ Unspecified
- ☐ Several times daily
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other

Section 3 - Consent to Leave a Message

By agreeing, you're allowing a SunWise (Doctor, Physician Assistant, or Medical Assistant) to leave a message on your phone concerning the results of your pathology. This is in the eventuality where you can not be reached. We will use the number we have on file.

Please circle one: YES NO

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Medical Release

____ ____________________
(Patient Name - Print) **(DOB)**

____
(Legal Guardian Name)

Authorizations

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to SunWise Dermatology & Surgery, LLC. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patients and to avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in the form of cash, check, Visa, MasterCard, Discover, or American Express. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and copayments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

____ ____________________
(Patient or Legal Guardian Signature) **(Today's Date)**

(Medicare Only) Medicare Health Insurance Form

I request that payment of authorized Medicare benefits be made either to me or my behalf to SunWise Dermatology & Surgery, LLC for any services furnished to me by SunWise Dermatology & Surgery, LLC. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

____ ____________________
(Patient or Legal Guardian Signature) **(Today's Date)**

Medical Information Release Authorization

____
(Medical information may be released to)

____ ____________________
(Relationship) **(Phone)**

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Financial Policy

We appreciate the opportunity to serve you, and want to thank you for choosing SunWise Family Dermatology & Surgery. We are committed to your treatment success and strive for providing you excellence in service. Prior to receiving any services, we do require you to read and sign the following statement regarding our Financial Policy:

Forms of Payment: We accept cash, check, Visa, MasterCard, American Express and Discover.

Patient Responsible Balances Due at the Time of Service: Co-pays that are required by your insurance policy are due at the time of service. If you have no insurance and are self-pay, or if having an elective non-covered service, your balance in full is required at time of service. If you or any of your family members have an outstanding balance, we may ask for payment of this balance at this time.

Insurance Billing: As a courtesy to our patients, we bill most major insurance carriers directly. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you have provided to us or them or your failure to obtain a referral, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will ordinarily help you as best as possible to get proper and timely payment from your insurance.

Minor Patients: A parent or legal guardian must accompany minors at EVERY visit, this person becomes the responsible party. Unaccompanied minors will have to reschedule to a date a parent can attend. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.

Missed Appointment Fees:

- If you miss, cancel or reschedule an appointment within less than 24 hours of the appointment time, there may be a **$25 fee** assessed to your account, depending on the circumstances and previous appointment history.

- Missed surgery appointments: We need 48 hours notice to change a surgery appointment or a fee of **$100** will be assessed to your Account.

Returned Check Fees: If your check is returned by the bank due to insufficient funds in your account, there will be a **$36 fee** assessed to your account.

Account Balances: Please pay your bill promptly or call us at your earliest convenience if you have any questions about your balances due. Our general policy is that balances due be paid within 30 days. Outstanding balances not paid within 60 days may be turned over to a collection agency, resulting in further finances charges and reporting to national credit bureaus, such as Trans-Union, Experian and Equifax. Please contact us immediately if special financial circumstances arise, as we may be able to arrange a payment plan.

Thank you for taking time to read and understand our Financial Policy. Please let us know if you have any questions or concerns.

Telephone Consumer Protection Act (TCPA): You agree, in order for us to service your account or to collect monies you may owe, **SunWise Family Dermatology & Surgery**, and/or our agents may contact you by telephone or any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/we have read this disclosure and agree that SunWise Family Dermatology & Surgery, it employees and/or agents may contact me/us as described above. **My signature below indicates that I have read, understand and agree to the terms of this Financial Policy.**

____ ____________________

(Signature of Patient or Responsibility Party) **(Date)**

____

(Printed Name)

____ ____________________

(Patient Name - Print) **(Patient DOB)**

____

(Legal Guardian Name - Print)

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Consent to Treat a Minor

____
(Today's Date)

____ ____________________
(Patient Name) **(Date of Birth)**

____
(Street Address, City, State, Zip)

____ ____________________
(Responsible Party's Name) **(Phone)**

____ ____________________
(Emergency Contact) **(Phone)**

The undersigned hereby requests and authorizes SunWise Dermatology & Surgery, LLC. to perform tests, procedures and render treatment to ___________________________________, a minor.
(**Patient Name)**

This authorization extends to all SunWise Dermatology & Surgery, LLC offices, doctors, physician assistants, and office staff members.
If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize the care should be revoked or modified in any way, the undersigned does hereby agree to notify SunWise Dermatology & Surgery, LLC as soon as possible.

As of the date below, the undersigned states and avows to have the legal right to select and authorize health care services for the minor named above.

____ __________________
(Signature of Person Authorize to Sign for Patient **(Date)**

____
(Printed Name)

_____________________________________ ____
(Relationship to Patient) **(Witness)**

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HIPAA Patient Privacy and Rights Disclosure

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
PATIENT PRIVACY AND RIGHTS DISCLOSURE**

SunWise Family Dermatology & Surgery and its employees disclose information given to us by you, your insurance company, primary care doctor and/or other medical professionals strictly for the purpose of treatment, payment of services rendered or health care operations.

We do not sell mailing lists or disclose personal information about our patients except that which is needed to carry out our objectives, which is your health.

In compliance with HIPAA guidelines, the patient understands that they have the right to review any information which is documented in the patient's record by our office and right to add an addendum to such records if recorded information is disputed.

By signing this consent, you agree to allow SunWise Family Dermatology & Surgery to use and disclose personal information about you for the reasons above. You have the right to revoke this consent at anytime but must be aware that we cannot guarantee your care unless we can communicate with other health professionals when necessary.

This notice of privacy will become a part of the patient's medical record.

____ _______________
(Signature) **(Date)**